Colorado Department of Public Health and Environment

Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
E-mail: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

FW

Request for Fee Waiver/Tax-Exempt Status

Instructions:

1. Complete all required sections of the form neatly and accurately.
2. **There are no fees to file this form.**
3. **Do not write-over, cross-out, or use white-out on this form, or it will be voided**. If you make a mistake on the form, please complete a new one.
4. After completing the form, you must sign and date it in front of a notary and have it notarized.
5. **Include a copy of your valid Colorado ID.** The chart below lists the documents the Registry will accept:

PROOF OF IDENTITY	
The Registry requires a verifiable, photo ID for all forms. Please submit one of the following IDs with your form:	
• Colorado Driver's License • Colorado photo ID • Temporary Colorado Driver's License • Temporary Colorado ID	• Out-of-state Driver's License • Out-of-state photo ID • U.S. Passport • Military ID (copy of front and back) • Tribal ID
i. All documents must be currently valid when received at the Registry. ii. Damaged, expired, or tampered IDs are not valid. iii. The address on the photo ID **does not** have to match the mailing address on the form. iv. All IDs must be verifiable and have specific issue and expiration dates. v. The ID must show the patient's date of birth.	

6. Patient social security numbers are used to confirm identity and protect confidentiality.
7. Tax-exempt status allows patients to apply for a Medical Marijuana Registry card without paying the application fee. It also allows patients to purchase medical marijuana without paying Colorado sales taxes. You may qualify for a fee waiver if your household income is 185% of the Federal Poverty Level or less. The chart below indicates the annual household incomes, adjusted for family size, that qualify.

Household incomes at 185% of 2012 Federal Poverty Guidelines*
Source: Federal Register, Vol. 75, No. 17, January 26, 2012, pp. 4034-4035

# in Family	Annual Income
1	$ 20,664.50
2	$ 27,990.50
3	$ 35,316.50
4	$ 42,642.50
5	$ 49,968.50
6	$ 57,294.50
7	$ 64,620.50
8	$ 71,946.50
Each additional	$ 7,067.00

* Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)

8. To prove household income, you must submit a certified copy of your most current State tax return. Tax returns must be within the last two years to qualify. You can request a certified copy of your tax return by completing form DR-5714 'Request for Copy of Tax Returns' available at www.colorado.gov/cms/forms/dor-tax/dr5714.pdf. The form must be completed, notarized and sent to the Colorado Department of Revenue for processing.

9. Incomplete Requests for Fee Waiver/Tax Exempt forms will be voided and returned to you. The form is considered complete when:
   a. The form is completed, signed and notarized.
   b. A copy of the patient's Colorado photo ID **or** out-of-state ID and proof of Colorado residency is included.
   c. A certified copy of your most current State tax return.
10. Make a copy of all your paperwork. Keep the copy for your files. Submit your originals to the Registry.
11. **To have the application fee waived,** this form must be submitted with your application packet.
12. **To request a change in tax-exempt status after you have your Registry card,** submit the complete form to the Registry within 10 days of the date it is notarized.
13. Unless a fee is required, DO NOT send money to the Registry. All monies received at the Registry are nonrefundable.
14. Please allow 4 to 6 weeks from the date the Registry receives your paperwork for processing. If you have not received a response within 6 weeks, please contact the Registry at 303-692-2184. Your paperwork or card will be mailed to the address on your paperwork. Cards are not valid outside of Colorado, thus the Registry does not mail cards outside of the State.
15. Submit paperwork by mail or deliver to the Registry's drop-box. **The Registry does not accept forms by fax or e-mail.**

Mail to:

Application Processing
Colorado Dept. of Public Health & Environment
HSV-MMR
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, South East Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

For more information, visit our website www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.

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STAFF ONLY

_____
Evaluated

_____
Replacement Card Printed

Corrections:

Request for Fee Waiver/Tax-Exempt Status

This form is not valid as a temporary registry card.

See instructions on page 1. Photo ID required with all forms.

1. Social Security Number (optional) - -	**Section A: Patient Information (Required)** The name on the form must match the legal name on your photo ID.		
2. Last Name	3. First Name		4. Middle Initial
5. Mailing Address	5a. Apartment/Suite #	6. City	
State **CO**	7. Zip Code	8. County	9. Date of Birth - -	10. Telephone Number ( ) -
11. E-mail Address (optional)*			12. Gender ☐ Male ☐ Female

* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.

13. ☐ I am enclosing a certified copy of the previous year's Colorado tax return as proof of income. (Required.)

14. Income criteria is based on household size. Please list all individuals included on your Colorado tax return.

List all the people in the household who were listed on your Colorado tax return.			
Last Name	**First Name**	**Date of Birth (mm/dd/yyyy)**	**Relationship to Patient**
1.		- -	
2.		- -	
3.		- -	
4.		- -	
5.		- -	
6.		- -	
☐ Please see additional family member names on back. There are _____ (# of people) additional names on the back.			

I hereby certify that all information provided is correct and complete.	
15. Applicant's Signature: ▶	16. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County, Colorado
(Name of patient printed by notary) (County name)

on this _____ day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date)

AFFIX NOTARY SEAL

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Patient's Name: _____ **Patient's Social Security Number:** ___-___-___

STAFF ONLY

_____
Evaluated

Corrections:

List all the people in the household who were listed on your Colorado tax return.			
Last Name	**First Name**	**Date of Birth (mm/dd/yyyy)**	**Relationship to Patient**
7.		- -	
8.		- -	
9.		- -	
10.		- -	
11.		- -	
12.		- -	
13.		- -	
14.		- -	
15.		- -	
16.		- -	
17.		- -	
18.		- -	
19.		- -	
20.		- -	